Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 705-4647
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 3/30/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left L5 Transforaminal Epidural Steroid Injection with fluoroscopy; CPT: 64483, 77003.26

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Pain Management & Anesthesiology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	**(Agree) X**
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
This individual sustained a back injury in xx/xxxx. He underwent L4-5 micro diskectomy on 10/03/11. Subsequent to the surgery he had two left L5 transforaminal epidural steroid injections in 2011. The first injection achieved 20% relief and the second one achieved no relief. He had a left L5 transforaminal epidural steroid injection on 5/27/14 with minimal relief. There is persistent back and left leg pain with slight motor weakness in the left leg. MRI shows multi-level foraminal stenosis. A spinal cord stimulator was offered, but the patient declined the modality. He underwent 80 hours of a functional restoration program and subsequently stated that he did not want to return to work.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion:
I agree with the benefit company's decision to deny the left L5 transforaminal epidural steroid injection with fluoroscopy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)
Rationale: ODG require 50 to 70% pain relief at 6 to 8 weeks after the first epidural steroid injection to approve a second one. This individual has had multiple epidural steroid injections with little or no relief. ODG are not met for the requested procedure.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)